

MEDICAL NUTRITION TREATMENT NOTES

Name: _____ Date of Birth: ____/____/____

Initial Meeting Date: ____/____/____ Referred by: self, doctor, specialist, therapist, other

MEDICAL HISTORY: (please circle appropriate response above)

List all **medications** you are taking right now along with all **health conditions** that you currently suffer from:

Family history (please circle): diabetes cancer high cholesterol high blood pressure heart attack stroke

List any other health conditions that run in your family that you do not currently suffer from: _____

List any supplements you take (such as vitamins): _____

DIETARY HISTORY:

How many **meal-sized** portions do you eat a day? _____ How many **snack-sized** portions? _____

How often do you eat out, or get take-out? _____ per (circle) **day week month**

Do you drink alcohol?(circle) **yes no** How often? _____ per (circle) **day week month**

Do you smoke? (circle) **yes no never** How much per day? _____ When quit? _____

Who shops for food? _____ Who prepares meals? _____ For how many? _____

If you have ever "dieted" to gain or lose weight, please briefly list the types and how much you lost/gained? _____

List physical activities you currently do routinely: _____

List any food intolerances or food allergies: _____

PERSONAL HISTORY:

List the people you live with: _____

Do you work? _____ What do you do? _____

How many hours per week? _____ Which shift? _____ Level of stress? _____

PHYSICAL: (Please fill in what you can or leave the space blank)

Weight: _____ Height: _____ Age: _____ Actual weight: _____ BMI: _____

Currently, are you (circle): gaining weight, losing weight, or maintaining your weight?

Do you sleep well? Y/N Is your digestion normal? Y/N Women, are you periods normal? Y/N

Highest weight: _____ Lowest weight: _____ Last weight happy at: _____

Cholesterol: _____ Fasting Blood Sugar: _____ A1C: _____

Blood Pressure: _____ List any abnormal lab values: _____

What would you like to address with the dietitian: _____
